



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
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PHONE 208-334-6626
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August 30, 2006

Todd Winder, Administrator
Oneida County Clinic
150 North 200 West
Malad City, Id 83252

Dear Mr. Winder:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Oneida County Clinic, on August 23, 2006.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

Gary Guiles
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 08/23/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13T016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/23/2006
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY CLINIC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 BANNOCK ST. MALAD CITY, ID 83252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
J 000	INITIAL COMMENTS No deficiencies were cited during the initial Medicare certification survey of your rural health clinic. Oneida County Clinic is in compliance with the requirements of 42 CFR Part 481, Conditions of Coverage for Rural Health Clinics. The surveyors conducting the initial Medicare certification survey were: Gary Guiles, RN, HFS, Team Leader Penny Salow, R.N., H.F.S.	J 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.